Correspondence.

DYSMENORRHOEA.

SIR,—In an able and suggestive lecture reported in the JOURNAL of March 19th Dr. Gibbons refers to a theory of causation of this disease which has been advanced by Dr. Herman,[1] and which I ventured to criticize in a letter to the JOURNAL of May 15th.

Briefly to recall this theory, its author ascribes the characteristic spasmodic pain to the faulty development of a centre controlling the movements of the genital canal, which centre is assumed by him to exist in the spinal cord or sympathetic system. In my former letter, after calling attention to the cases which developed dysmenorrhoea after years of painless menstruation, I asked for information—and in vain—as to the degree of development of this hypothetical "sexual" centre in such cases. "Their painless history of years' duration effectively debars any association with such a maldeveloped sexual centre."

I was gratified to read of the employment of this argument by Dr. Gibbons, in stating a case against the complete acceptance of Dr. Herman's theory. In like manner, Theilhaber's well-known view of the etiological factor in this condition receives criticism at his hands, but not on the same grounds, which is rather surprising. Instead, Dr. Gibbons emphasizes the occurrence of hypertrophy of the uterine musculature, which he believes to exist, because "in nearly all cases of well-marked dysmenorrhoea in which I have operated the sound measured an increase of ¼ in. to ½ in. For this reason, he rejects Theilhaber's theory that a badly-developed uterine muscle is the *fons et origo* of the disease. But surely an increase of a fractional part of an inch in the length of the uterine cavity, as measured by a graduated sound, is not seriously offered as evidence of an existing hypertrophy of its walls. On the contrary, hypertrophy of the musculature of such a hollow spheroidal viscus as the uterus, must be concentric in disposition, and of necessity encroach upon the actual capacity of the contained cavity.

Moreover, within certain limits—depending upon the inherent elasticity of the tissues—the reading obtained from the sound will depend upon the drag exerted on the cervix while the length of the cavity is being determined; pull hard enough upon the vulsellum, and a reading which will repose comfortably in any tables of statistics in course of preparation will be secured. I trust these comments of mine upon an admirable lecture savour not of a piece of destructive criticism. Such, at any rate, was not the vein in which they were penned.—I am, etc.,

Dukinfield, March 22nd. GERALD RALPHS, M.B.Vict.

SIR,—It was with great interest that I read Dr. R. A. Gibbons's lecture on dysmenorrhoea in the JOURNAL of March 19th, and noted carefully his own theory as well as that of others quoted by him regarding the etiology of dysmenorrhoea. Having attended and cured hundreds of these cases of simple dysmenorrhoea, I must say I cannot see why we cannot accept, without looking any deeper, the simple theory that the cause of these spasmodic painful contractions of the uterus at the menstrual period is due to a cervix of small lumen. In such a case, pure and simple, menstruation will take place without any pain if the nervous system is in a normal condition; such a person may have no dysmenorrhoea for some time after that physiological act has become established, but if for various reasons vasomotor nervous disturbances take place, whether from the effects of a chill the result of a severe wetting, illness, fright, grief, shock, or other such causes, this upset to the nervous system interferes with the regulation and control of blood supply to the part, and as a result an *over*-supply at each menstruation, which in cervical canal of normal lumen would have no obstructive effect, in an abnormally small lumen will cause a sufficient obstruction to bring about dysmenorrhoea, the pain of which is not relieved until the flow is fully established, the latter being only brought about by dilatation of the cervix. There is likely to be, of course, in these cases, the highly sensitive mucous membrane of the uterus, which Dr. Gibbons has noticed, and one which becomes turgid on irritation by a foreign body—such as a probe—and producing painful uterine contractions. A single artificial dilatation of such a cervical canal is in some cases sufficient to bring about a cure even if it only causes the minutest increase in the permanent enlargement of its lumen, though I have seldom found such cases to require this latter procedure, provided the nervous system of these patients is properly attended to and for a sufficient length of time, the excessive menstrual turgescence of the uterus being in the meantime kept under control with such drugs as cannabine tannate, ergotin, and cotarnin hydrochlor., etc.—I am, etc.,

Manchester, March 28th. MARTIN J. CHEVERS.

[1] BRITISH MEDICAL JOURNAL, April 17th, 1909.

SIR,—I desire to protest most earnestly against the recommendation, contained in the address on dysmenorrhoea by Dr. Gibbons, to treat dysmenorrhoea by repeated doses of brandy. There is no man of experience in general practice who does not, again and again, see cases where homes are wrecked and families ruined by this treatment.

Then, again, what is the use or meaning of the recommendation to apply a thick layer of wool "*sometimes sprinkled with laudanum?*" I had thought that it was now generally known that opium acts as an analgesic only when it comes into contact with the brain cells. If this is so, to apply it to the abdomen sprinkled on wool is about as reasonable as the Chinese method of treating prolapsus uteri by a blister on the scalp.—I am, etc.,

London, W., March 24th. J. MCNAMARA, M.D.

SIR,—One reader of Dr. Gibbons's lecture on dysmenorrhoea (BRITISH MEDICAL JOURNAL, March 19th) has demurred to his recommendations of brandy in the treatment of this affection. May I be allowed to call attention to another minor point in the treatment of dysmenorrhoea advocated by Dr. Gibbons, namely, the application of laudanum or equal parts of liniment of aconite and liniment of belladonna to the abdomen? These applications, he says, are "particularly soothing, combined with the heat."

This statement is directly at variance with the results of a series of experiments to determine the action of various reputed anodynes on the unbroken skin described in the BRITISH MEDICAL JOURNAL two weeks previously (by A. R. Short, M.D., and W. Salisbury).

As Dr. Hale White says in his well-known *Materia Medica*, "probably it is the heat and not the opium which relieves the pain," and the same presumably may be said of the application of liniment of aconite and liniment of belladonna "combined with heat."

Is it not time that the question of local analgesia should be settled authoritatively, and on a scientific basis? At present the teaching seems to be based mainly on tradition, which—if any value is to be attached to the experiments to which allusion has been made—is for the most part misleading.—I am, etc.,

Brighton, March 26th. E. WEATHERHEAD.

THE DANGERS OF THE ARYLARSONATES.

SIR,—I endorse Mr. J. Ernest Lane's statement, "that there was, therefore, in the medical journals some indication that these drugs were not quite so innocent as they had been depicted." In September, 1908, I wrote[1] that atoxyl has given rise to many cases of toxic poisoning, as well as to many cases of *total blindness* in treating sleeping sickness. This is attributed to *adulteration* of the drug, but the symptoms appear to be those of ordinary arsenical poisoning, namely, "gastro-intestinal pains, nausea, vomiting, painful micturition, and painful sensations in the limbs"—that is, arsenical neuritis, these symptoms possibly being due to intramuscular injections, as can occur with insoluble injections of mercury.

I do not, on the evidence presented, concur in Colonel Lambkin's view:

> That one important fact has been established—that is, that in these salts (arylarsonates) we are now in possession of a *specific* for syphilis, and the importance of this cannot well be exaggerated. . . . Injections of soamin can be looked on as prophylactic in the majority of cases against any further development of the disease, if given early and in sufficient quantities.[2]

[1] *British Journal of Dermatology*, November and December, 1908.

[2] Colonel Lambkin, R.A.M.C., BRITISH MEDICAL JOURNAL, August 15th, 1908, pp. 391-394.